		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0017319

Facility Name: ALDEN LAKELAND REHAB & HCC

Address: 820 W. LAWRENCE AVE. (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 286-3883 **Fax #** (773)286-3743

IDPA ID Number: 36-2687662

Date of Initial License for Current Owners: 01/01/72

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: STEVEN M. KROLL **Telephone Number:** (773) 286-3883

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) STEVEN M. KROLL

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	50,111	3,934	6,063	60,108	8
9	SNF/PED					9
10	ICF	13,844			13,844	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,955	3,934	6,063	73,952	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.54%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 5,797

Medicare Intermediary AdminiStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	314,271	37,942		352,213	(24,244)	327,969		327,969			1
2	Food Purchase		495,483		495,483		495,483	(85,271)	410,212			2
3	Housekeeping	246,423	51,965		298,388	1,666	300,054		300,054			3
4	Laundry	84,653	43,972		128,625	138	128,763		128,763			4
5	Heat and Other Utilities			272,853	272,853		272,853		272,853			5
6	Maintenance	141,984		252,628	394,612	108	394,720	28,293	423,013			6
7	Other (specify):*											7
8	**TOTAL General Services**	787,331	629,362	525,481	1,942,174	(22,332)	1,919,842	(56,978)	1,862,864			8
	B. Health Care and Programs											
9	Medical Director			45,000	45,000		45,000		45,000			9
10	Nursing and Medical Records	2,341,837	426,431	7,710	2,775,978	5,460	2,781,438	(69,225)	2,712,213			10
10a	Therapy	52,891			52,891		52,891		52,891			10a
11	Activities	104,344	6,281	2,310	112,935		112,935		112,935			11
12	Social Services	34,398		840	35,238		35,238		35,238			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,533,470	432,712	55,860	3,022,042	5,460	3,027,502	(69,225)	2,958,277			16
	C. General Administration											
17	Administrative	209,711			209,711		209,711		209,711			17
18	Directors Fees											18
19	Professional Services			1,133,406	1,133,406	(25,000)	1,108,406	(1,026,894)	81,512			19
20	Dues, Fees, Subscriptions & Promotions			31,676	31,676		31,676	(17,838)	13,838			20
21	Clerical & General Office Expenses	556,515	23,525	43,409	623,449	64	623,513	102,597	726,110			21
22	Employee Benefits & Payroll Taxes			674,089	674,089	16,808	690,897	83,060	773,957			22
23	Inservice Training & Education											23
24	Travel and Seminar			515	515		515	16,238	16,753			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			152,219	152,219		152,219	688	152,907			26
27	Other (specify):*			94,563	94,563		94,563	(94,563)				27
28	**TOTAL General Administration**	766,226	23,525	2,129,877	2,919,628	(8,128)	2,911,500	(936,712)	1,974,788			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,087,027	1,085,599	2,711,218	7,883,844	(25,000)	7,858,844	(1,062,915)	6,795,929			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC #0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			138,535	138,535		138,535	476,518	615,053			30
31	Amortization of Pre-Op. & Org.							10,216	10,216			31
32	Interest			273,189	273,189		273,189	766,308	1,039,497			32
33	Real Estate Taxes					25,000	25,000	301,655	326,655			33
34	Rent-Facility & Grounds			1,503,343	1,503,343		1,503,343	(1,502,517)	826			34
35	Rent-Equipment & Vehicles			11,970	11,970		11,970	30,836	42,806			35
36	Other (specify):*							58,326	58,326			36
37	**TOTAL Ownership**			1,927,037	1,927,037	25,000	1,952,037	141,342	2,093,379			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,300,564	561,536	1,664,732	3,526,832		3,526,832	(611,565)	2,915,267			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	1,300,564	561,536	1,828,982	3,691,082		3,691,082	(611,565)	3,079,517			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,387,591	1,647,135	6,467,237	13,501,963		13,501,963	(1,533,138)	11,968,825			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	87,490	30		9
10	Interest and Other Investment Income	(8,043)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(540)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,834)	32		18
19	Entertainment				19
20	Contributions	(7,390)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(94,563)	27		24
25	Fund Raising, Advertising and Promotional	(5,115)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,527)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (36,522)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(672,267)	pg 6's	34
35	Other- Attach Schedule	(824,349)	pg 5a	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,496,616)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,533,138)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ALDEN LAKELAND REHAB & HCC

ID# 0017319

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PAC FEE - ILL HEALTH CARE	$ (1,200)	20	1
2	Delete non-allowable marketing fee (gl 5755)	(65,703)	19	2
3	back out non-cost: gl 5026 hmo nurs supply	(43,176)	39	3
4	back out non-cost: gl 5080 hmo oxyg cost	(29,769)	39	4
5	back out non-cost gl 5040 hmo therapy contra all	(367,334)	39	5
6	back out non-cost: part b contract. Allow.'s	(9,759)	39	6
7	back out non-cost:hmo drug contra-allow gl 5046	(50,454)	39	7
8	back out related party interest gl 7105	(263,412)	32	8
9	decrease insur exp adj (late audit adj)	(8,700)	26	9
10	record def maint exp on painting: 1999	4,206	6	10
11	record def maint exp on painting: 1998	8,575	6	11
12	record def maint exp on painting: 2000	2,377	6	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(824,349)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(540)	0	0	(84,731)	0	0	0	0	0	0	0	(85,271)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	15,158	0	13,157	0	0	0	(22)	0	0	0	0	28,293	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	14,618	0	13,157	(84,731)	0	0	(22)	0	0	0	0	(56,978)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(68,124)	(1,101)	0	0	0	0	0	0	(69,225)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(68,124)	(1,101)	0	0	0	0	0	0	(69,225)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(65,703)	2,800	(963,991)	0	0	0	0	0	0	0	0	(1,026,894)	19
20	Fees, Subscriptions & Promotions	(18,232)	0	394	0	0	0	0	0	0	0	0	(17,838)	20
21	Clerical & General Office Expenses	0	624	38,084	56,843	7,046	0	0	0	0	0	0	102,597	21
22	Employee Benefits & Payroll Taxes	0	0	81,616	0	1,444	0	0	0	0	0	0	83,060	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	16,238	0	0	0	0	0	0	0	0	16,238	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(8,700)	9,388	0	0	0	0	0	0	0	0	0	688	26
27	Other (specify):*	(94,563)	0	0	0	0	0	0	0	0	0	0	(94,563)	27
28	**TOTAL General Administration**	(187,198)	12,812	(827,659)	56,843	8,490	0	0	0	0	0	0	(936,712)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(172,580)	12,812	(814,502)	(96,012)	7,389	0	(22)	0	0	0	0	(1,062,915)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	87,490	375,406	11,855	0	1,767	0	0	0	0	0	0	476,518	30
31	Amortization of Pre-Op. & Org.	0	0	306	0	0	9,910	0	0	0	0	0	10,216	31
32	Interest	(275,289)	973,217	47,859	0	2,698	17,823	0	0	0	0	0	766,308	32
33	Real Estate Taxes	0	292,570	8,625	0	460	0	0	0	0	0	0	301,655	33
34	Rent-Facility & Grounds	0	(1,503,343)	826	0	0	0	0	0	0	0	0	(1,502,517)	34
35	Rent-Equipment & Vehicles	0	0	30,836	0	0	0	0	0	0	0	0	30,836	35
36	Other (specify):*	0	58,326	0	0	0	0	0	0	0	0	0	58,326	36
37	**TOTAL Ownership**	(187,799)	196,176	100,307	0	4,925	27,733	0	0	0	0	0	141,342	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(500,492)	0	0	(22,780)	(53,812)	(34,481)	0	0	0	0	0	(611,565)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(500,492)	0	0	(22,780)	(53,812)	(34,481)	0	0	0	0	0	(611,565)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(860,871)	208,988	(714,195)	(118,792)	(41,498)	(6,748)	(22)	0	0	0	0	(1,533,138)	45

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See Page 6K		See Page 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,503,343	Lawrence Ave. Building Limited Partnership		$	$ (1,503,343)	1
2	V	32	Interest Income	3,786	Lawrence Ave. Building Limited Partnership			(3,786)	2
3	V	19	Accounting Fees		Lawrence Ave. Building Limited Partnership		2,800	2,800	3
4	V	21	Misc. G & A Expenses		Lawrence Ave. Building Limited Partnership		624	624	4
5	V	33	Real Estate Taxes		Lawrence Ave. Building Limited Partnership		292,570	292,570	5
6	V	26	Insurance		Lawrence Ave. Building Limited Partnership		9,388	9,388	6
7	V	32	Interest on Mortgage		Lawrence Ave. Building Limited Partnership		977,003	977,003	7
8	V	36	Mortgage Ins. Prem.		Lawrence Ave. Building Limited Partnership		58,326	58,326	8
9	V	30	Depreciation		Lawrence Ave. Building Limited Partnership		375,406	375,406	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,507,129			$ 1,716,117	$ * 208,988	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits	$	Alden Management Services, Inc.	100.00%	$ 81,616	$ 81,616	15
16	V	19	Management fees	978,300	Alden Management Services, Inc.		14,309	(963,991)	16
17	V	21	Gen'l & Admin.		Alden Management Services, Inc.		38,084	38,084	17
18	V	6	maintenance/utilities		Alden Management Services, Inc.		13,157	13,157	18
19	V	24	autos/seminars		Alden Management Services, Inc.		16,238	16,238	19
20	V	20	dues/subscriptions		Alden Management Services, Inc.		394	394	20
21	V	30	depreciation		Alden Management Services, Inc.		11,855	11,855	21
22	V	31	amortization		Alden Management Services, Inc.		306	306	22
23	V	33	real estate tax		Alden Management Services, Inc.		8,625	8,625	23
24	V	34	rent		Alden Management Services, Inc.		826	826	24
25	V	35	rent-equipt/vehicles		Alden Management Services, Inc.		30,836	30,836	25
26	V	32	interest		Alden Management Services, Inc.		47,859	47,859	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 978,300			$ 264,105	$ * (714,195)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	TUBE FEEDING	$ 152,458	PYRAMID HEALTH CARE SERVICES	100.00%	$ 67,727	$ (84,731)	15
16	V	10	NURSING SUPPLIES	140,849	PYRAMID HEALTH CARE SERVICES		72,725	(68,124)	16
17	V	39	SUPPLIES / PER DIEM FEES	55,560	PYRAMID HEALTH CARE SERVICES		32,780	(22,780)	17
18	V	21	GEN'L & ADMIN		PYRAMID HEALTH CARE SERVICES		56,843	56,843	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 348,867			$ 230,075	$ * (118,792)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 148,939	Forum Extended Care II	100.00%	$ 116,705	$ (32,234)	15
16	V	10	house stock	5,087	Forum Extended Care II		3,986	(1,101)	16
17	V	39	iv	99,701	Forum Extended Care II		78,123	(21,578)	17
18	V	22	fringe benefits		Forum Extended Care II		1,444	1,444	18
19	V	21	gen'l & admin		Forum Extended Care II		7,046	7,046	19
20	V	32	interest		Forum Extended Care II		2,698	2,698	20
21	V	33	real estate tax		Forum Extended Care II		460	460	21
22	V	30	depreciation		Forum Extended Care II		1,767	1,767	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 253,727			$ 212,229	$ * (41,498)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	CPT Revenues	$ 1,125,825	Community Physical Therapy	100.00%	$ 1,091,344	$ (34,481)	15
16	V	31	Amortization		Community Physical Therapy		9,910	9,910	16
17	V	32	Interest		Community Physical Therapy		17,823	17,823	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,125,825			$ 1,119,077	$ * (6,748)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance expense	$ 3,527	Alden Bennett Construction	100.00%	$ 3,505	$ (22)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,527			$ 3,505	$ * (22)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	100.00	331,791	4.368	7.28	salary	$ 26,034	21-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.00	74,282	4.368	7.28	salary	5,828	21-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	67,859	4.368	7.28	salary	5,324	21-1	3
4											4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10											10
11											11
12											12
13								TOTAL	$ 37,187		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See 8a… attached.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	US Dpt. Of Hud		x	mortgage	varies	3/94	$ 119,777,000	$ 11,636,244	12/34	8.3800	$ 977,003	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Related Party - CPT	X		Operations	None						17,823	6
7	Related Party - AMS/FECII	x		Operations	None		AMS=47,859				50,557	7
8												8
9	TOTAL Facility Related						$ 119,777,000	$ 11,636,244			$ 1,045,383	9
	B. Non-Facility Related*											
10											(3,786)	10
11											(2,100)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,886)	14
15	TOTALS (line 9+line14)						$ 119,777,000	$ 11,636,244			$ 1,039,497	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	391,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	337,570	2
3. Under or (over) accrual (line 2 minus line 1).	$	(53,430)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	346,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	25,000	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	317,570	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	380,446	8
	1997	368,272	9
	1998	354,967	10
	1999	372,295	11
	2000	337,570	12

LINE 4: 2001 ACCRUAL BASED ON AN ESTMATED 5% INCREASE OF ACTUAL BILL PAID IN 2001:

$337,570.16 X 1.025 = 346,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALDEN LAKELAND REHAB & HCC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0017319

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-419-040-0000	Nursing home facility	$ 337,570.16	$ 337,570.16
2.		Related party - Alden Management	$ 118,551.00	$ 8,625.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 456,121.16	$ 346,195.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	300 BED FACILITY		1995	$ 1,040,001	1
2					2
3	TOTALS			$ 1,040,001	3

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 18,359	$	22	$	$	$ 18,359	4
5	300			1978	8,882,363	221,780	40	222,059	279	1,671,698	5
6			1995		577		40	14	14	92	6
7			1995		245		40	6	6	39	7
8				1996	13,250	331	40	331	(0)	1,960	8
	Improvement Type**										
9	Related Party-Forum:										9
10	Leasehold Improvement-Remodeling			1980	19,335		20			19,335	10
11	Leasehold Improvement-Remodeling			1980	1,208		10			1,208	11
12	Leasehold Improvement-Remodeling			1986	645		5			645	12
13	Leasehold Improvement-Remodeling			1990	404		5			404	13
14	Leasehold Improvement-Remodeling			1991	94		5			94	14
15	Leasehold Improvement-Remodeling			1993	8,304	830	10	830		7,474	15
16	Leasehold Improvement-Remodeling			1993	6,504	671	9.7	671		6,035	16
17	Leasehold Improvement-sign			1994	261	22	12	22		174	17
18	Leasehold Improvement-dryvit			1995	443	44	10	44		310	18
19	Leasehold Improvement-new ac			1999	723	48	15	48		145	19
20	Leasehold Improvement-roof			1985	972	51	19	51		870	20
21	Leasehold Improvement-roof			1994	863	58	15	58		460	21
22	Leasehold Improvement-roof			1997	819	55	15	55		273	22
23	Leasehold Improvement-roof			1998	1,390	93	15	93		371	23
24	Leasehold Improvement-parking lot asphalt			2000	111	11	10	11		22	24
25	Leasehold Improvement-hallway lighting			2001	155	16	10	16		16	25
26	Leasehold Improvement-DAI			2001	195	19	10	19		19	26
27											27
28	Related Party-AMS:										28
29	Leasehold Improvement-Remodeling			1993	4,266		7			4,266	29
30	Leasehold Improvement-Remodeling			1994	2,112	64	7	64		2,112	30
31											31
32	Related Party-FECII:			1999	7,216	383	5	383		553	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	GENERAL REMODELING	1994	$ 1,640,753	$ 42,645	15	$ 109,384	$ 66,739	$ 770,246	37
38	NEW AIR CONDITIONER	1994	185,718	4,827	15	12,381	7,554	81,140	38
39	OXYGEN AND SUCTION SYSTEM	1994	89,080	2,315	15	5,939	3,624	41,237	39
40	3RD FLOOR NURSES STATION	1994	14,234	370	15	949	579	6,313	40
41	REBUILD SHOWERS AND STALL	1994	47,131	1,225	15	3,142	1,917	21,344	41
42	PATIENT ROOM LIGHTING	1994	34,763	903	15	2,318	1,415	15,419	42
43	CARPETING	1994	20,688	537	10	1,379	842	13,169	43
44	NEW DOOR LOCK AND HARDWARE	1994	25,312	658	10	1,687	1,029	16,320	44
45	VARIOUS OTHER ITEMS	1994	85,896	2,234	10	5,726	3,492	38,086	45
46	DECORATING	1986	5,000		3			5,000	46
47	DOCORATING,PUMPS, ROOF REPAIR, COMPRESSOR REPAIR	1987	15,543		3-5			15,543	47
48	ELECTRICAL REPAIRS, CARPENTRY,PUMP REPAIR	1988	15,804		5			15,804	48
49	PUMP REPAIR	1989	2,510		5			2,510	49
50	REPAIR: PUMPS AND COMPRESSOR	1990	32,782		5-10			32,782	50
51	REPAIR: PUMPS, FANS, HEATER,ROOF	1991	16,753		5			16,753	51
52	REPAIR: BOILER,FANS, THERMOSTAT	1992	32,033	478	5-20	478		31,248	52
53	COLOR RENDERING,REPAIR: COOLING TOWER, ELECT TIMER,	1993	8,916	490	5-15	490		5,765	53
54	DRAPERIES AND CUBICLES; COMPRESSOR REPAIR	1994	45,438	1,541	5-20	1,541		37,662	54
55	REPAIR: ELEVATOR, LAUNDRY ROOM, PUMPS,A.C, INSULLATIC	1995	415,705	22,315	5-20	22,315		172,397	55
56	NEW ELECTRIC GENERATOR, NEW COOLING TOWER	1996	191,725	9,510	5-20	9,510		56,997	56
57	INSTALL NEW CIRCUITS	1997	2,176	435	5	435		2,140	57
58	CLEAN FAN COILS	1997	4,622	924	5	924		4,236	58
59	REPAIR LIGHTING CIRCUIT & BALLAST	1997	2,327	465	5	465		2,172	59
60	REBUILD COMPRESSOR	1997	4,268	854	5	854		3,841	60
61	REPAIR CALL LIGHTS	1997	2,350	470	5	470		2,037	61
62	ISTALL NEW SMOKE DETECTOR	1997	2,661	532	5	532		2,306	62
63	SPRAYED FIREPROOFING	1997	3,965	793	5	793		3,370	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,918,967	$ 318,998		$ 406,488	$ 87,490	$ 3,152,773	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,918,967	$ 318,998		$ 406,488	$ 87,490	$ 3,152,773	1
2	Climate Service, Inc (replace fans)	1998	4,725	945	5	945		3,780	2
3	**'Wigdahl(replaced outlets)	1998	2,300	230	10	230		901	3
4	Wigdahl(replaced outlets)	1998	334	33	10	33		131	4
5	Long Elevator(modify restrictors)	1998	2,200	110	20	110		422	5
6	Incorporation(kickplates & correr guards)	1998	2,309	462	5	462		1,770	6
7	Incorporation(kickplates & larone)	1998	4,547	909	5	909		3,410	7
8	Shine Rite Maintenance (strip and refinish 30 rooms)	1998	6,480	1,296	5	1,296		4,860	8
9	Star Contractors (install locks)	1998	5,581	558	10	558		2,140	9
10	Supreme Sheet Metal (Fire dampers)	1998	10,000	667	15	667		2,333	10
11	CSI (replace fan coil units)	1998	6,340	423	15	423		1,409	11
12	Atash Fire & Safety (install annunciator panel)	1998	5,890	392	15	392		1,407	12
13	CSI (rebuild compressor)	1998	7,056	470	15	470		1,568	13
14	Supreme Sheet Metal (install fire dampers)	1998	11,680	1,168	10	1,168		3,796	14
15	Alden Bennett Construction (plan of correction)	1998	2,222	222	10	222		704	15
16	Supreme Sheet Metal (install fire dampers)	1998	7,750	775	10	775		2,390	16
17	Supreme Sheet Metal (install fire dampers)	1999	9,475	948	10	948		2,843	17
18	Patton (repair generator)	1999	1,702	114	15	114		340	18
19	Alden Bennett Construction(general)	1999	11,471	1,147	10	1,147		2,772	19
20	Welding Supply(oxygen piping installed)	1999	13,176	659	20	659		1,482	20
21	ISS/Chicago Sound &Comm.(call system)	1999	28,500	1,900	15	1,900		4,117	21
22	Alden Bennett Construction(general)	1999	23,289	1,571	15	1,571		3,272	22
23	Alden Bennet Construction- oxygen tank	1999	9,475	474	20	474		948	23
24	Alden Bennett Construction(oxyg tank)	1999	35,016	1,751	20	1,751		3,647	24
25	Supreme sheet metal-install fire dampers-delete duplicate	2000	(9,475)	(948)	10	(948)		(1,895)	25
26	Climate Service, Inc (repair boiler)	2000	4,892	245	20	245		448	26
27	A&B custom cable-install cable tv	2000	13,824	1,382	10	1,382		2,419	27
28	Fox Valley-install new fire safety pump	2000	4,423	221	20	221		387	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,144,149	$ 337,121		$ 424,612	$ 87,490	$ 3,204,573	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 12,144,149	$ 337,121		$ 424,612	$ 87,490	$ 3,204,573	1
2	Fox Valley-repair hvac pump	2000	1,969	98	20	98		172	2
3	System electric-circuit for sump pump	2000	2,361	118	20	118		197	3
4	System electric-emergency lighting	2000	5,190	346	15	346		548	4
5	System Electric-install circuits	2000	1,570	79	20	79		118	5
6	Fox Valley-install tank system	2000	1,755	70	25	70		105	6
7	GT Mechanical-repair boiler	2000	2,698	135	20	135		202	7
8	ABC-fireproofing	2000	2,503	125	20	125		167	8
9	ABC-seal & stripe parking lot	2000	977	98	10	98		114	9
10	Richard G. Radke-color rendering	1993	6,620		5			6,620	10
11	ABC-oxygen tank wiring	2000	9,475	3,158	3	3,158		5,001	11
12	ABC-oxygen tank wiring	2000	26,715	8,905	3	8,905		14,100	12
13	ABC-wallpapering	2000	3,543	1,181	3	1,181		1,378	13
14	EWS - Oxygen tank repairs	2001	2,157	180	8	180		180	14
15	Simplex Time Recorder (fire alarm repairs)	2001	1,810	70	15	70		70	15
16	Simplex Time Recorder (fire alarm repairs)	2001	1,529	59	15	59		59	16
17	GT Mechanical-replace trane rooftop unit	2001	17,800	593	15	593		593	17
18	Long Elevator-repair elevator	2001	757	32	10	32		32	18
19	Long Elevator-replace boards	2001	4,659	194	10	194		194	19
20	Alden Bennett - various	2001	1,720	100	10	100		100	20
21	Alden Bennett - various	2001	8,688	241	15	241		241	21
22	Alden Bennett - various	2001	11,481	191	15	191		191	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,260,126	$ 353,096		$ 440,586	$ 87,490	$ 3,234,956	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,073,553	$ 168,314	$ 168,314	$	VARIES	$ 944,398	71
72	Current Year Purchases	28,536	1,501	1,501		VARIES	1,265	72
73	Fully Depreciated Assets	179,888	855	855		VARIES	179,918	73
74								74
75	TOTALS	$ 2,281,977	$ 170,670	$ 170,670	$		$ 1,125,581	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	various	bus/van	1998-2000	$ 11,938	$ 3,797	$ 3,797	$	3	$ 6,200	76
77										77
78										78
79										79
80	TOTALS			$ 11,938	$ 3,797	$ 3,797	$		$ 6,200	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,594,042	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 527,563	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 615,053	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 87,490	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,366,737	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	n/a	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	n/a	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party… Lawrence Ave. Partnership

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ related party, cost is eliminated			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 10,770 Description: copy machine lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	n/a		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

skilled nursing on-site

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 182,339	$		$ 182,339	1
2	Licensed Speech and Language Development Therapist		hrs			64,449			64,449	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			184,105			184,105	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see pg 16a…	# of prescrpts			0	50,081		50,081	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program			1,300,564			0		1,300,564	12
13	Other (specify):	see pg 16a…				0	1,133,729		1,133,729	13
14	TOTAL			$ 1,300,564		$ 430,893	$ 1,183,810		$ 2,915,267	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC **#** 0017319 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 365,130	$ 459,995	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 135,000)	1,476,844	1,476,844	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	154,913	181,453	6
7	Other Prepaid Expenses	1,263	1,263	7
8	Accounts Receivable (owners or related parties)		677,518	8
9	Other(specify): deferred rent/escrows		346,813	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,998,151	$ 3,143,887	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		10,064,486	14
15	Leasehold Improvements, at Historical Cost	1,428,140	3,656,685	15
16	Equipment, at Historical Cost	820,835	2,232,045	16
17	Accumulated Depreciation (book methods)	(1,131,695)	(3,920,708)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe due from affiliates		179,779	22
23	Other(specify): deferred rent		158,625	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,117,279	$ 12,370,912	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,115,430	$ 15,514,799	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,824,892	$ 3,824,892	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	361,092	361,092	30
31	Accrued Taxes Payable (excluding real estate taxes)	49,679	49,679	31
32	Accrued Real Estate Taxes(Sch.IX-B)		346,000	32
33	Accrued Interest Payable		81,213	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Resident funds/credit balances	224,147	224,147	36
37	accrued exp/idpa/mortg payable/ins	600,044	669,262	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,059,854	$ 5,556,285	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,567,380	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	due to affiliates	35,979	35,979	43
44	intercompany payables	5,710,981	5,710,981	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,746,961	$ 17,314,341	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,806,815	$ 22,870,626	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (7,691,385)	$ (7,355,827)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,115,430	$ 15,514,799	48

***(See instructions.)**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,633,469)	1
2	Restatements (describe):		2
3	**External auditor's adjustments made after 2000 cost**		3
4	**report was submitted. These adj's have no effect on costs**		4
5	**(bad debt expense-non-allowable, and medicare revenue).**	44,995	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (6,588,474)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,102,911)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,102,911)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (7,691,385)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,507,127	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,507,127	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	328,280	6
7	Oxygen	497,954	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 826,234	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	452,024	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 452,035	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,153	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,153	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior year vendor adjustments/etc.	3,003	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,003	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,789,553	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,928,595	31
32	Health Care	4,319,546	32
33	General Administration	2,323,708	33
	B. Capital Expense		
34	Ownership	1,927,037	34
	C. Ancillary Expense		
35	Special Cost Centers	2,229,329	35
36	Provider Participation Fee	164,250	36
	D. Other Expenses (specify):		
37	note: will not balance due to related party info on pg 3 & 4		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,892,464	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,102,911)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,102,911)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not yet done **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,265	2,297	$ 64,278	$ 27.98	1
2	Assistant Director of Nursing			(21)		2
3	Registered Nurses	63,450	69,555	1,880,598	27.04	3
4	Licensed Practical Nurses	20,712	22,551	436,675	19.36	4
5	Nurse Aides & Orderlies	107,076	112,589	1,115,626	9.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,378	1,440	20,144	13.99	8
9	Activity Director	1,968	2,057	33,339	16.21	9
10	Activity Assistants	8,573	9,038	71,005	7.86	10
11	Social Service Workers	4,383	4,675	41,746	8.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,097	41,357	314,270	7.60	15
16	Dishwashers					16
17	Maintenance Workers	7,449	7,910	128,394	16.23	17
18	Housekeepers	28,471	29,734	246,423	8.29	18
19	Laundry	8,579	9,338	84,652	9.07	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,410	8,826	143,081	16.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,577	3,783	109,195	28.86	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,008	2,080	29,141	14.01	31
32	Other Health C: Clinical Support	2,831	2,990	25,399	8.49	32
33	Other(specify) Personnel	1,909	2,080	34,136	16.41	33
34	TOTAL (lines 1 - 33)	312,136	332,300	$ 4,778,081 *	$ 14.38	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	45,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,310	11-3	44
45	Social Service Consultant	16	840	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	61	$ 48,150		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	n/a	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
R Agpasa	administrator	0	$ 5,501
various exectutives	operations	0	84,346
D Dalicandro	administrator	0	4,912
DiPaola	administrator	0	9,999
R Glantz	administrator	0	71,665
J Palazzo	administrator	0	5,424
Tannen & Weber/$4847	administrator	0	27,864
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 209,711

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALDEN MANAGEMENT	Mngmnt fee & Mrktg fee	$ 1,044,003
Blackman Kallick	ACCOUNTING	15,275
SEE PAGE 21 A	LEGAL	31,703
MISC. FEES	MISC	538
SCHMIDT & SALZMAN	LEGAL	158
MAYER, BROWN & PLATT	REAL ESTATE TAXES	25,000
JCAH	ACCREDITATION	7,781
CITY OF CHICAGO	LICENSE	1,755
ALDEN MANAGEMENT	CONSULTING	4,493
US GAS & ENERGY	CONSULTING	2,700
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,133,406

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,288
Unemployment Compensation Insurance	70,634
FICA Taxes	366,123
Employee Health Insurance	46,225
Employee Meals	24,417
Illinois Municipal Retirement Fund (IMRF)*	
UNION HEALTH & WELFARE	89,127
PENSION	29,714
TUITION REIMBURSEMENT	4,171
EMPLOYEE RELATIONS	4,702
HEAD TAX	2,097
MISC. COSTS	4,399
related party-ams	83,060
TOTAL (agree to Schedule V, line 22, col.8)	$ 773,957

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	
Health Care Worker Background Check	693
(Indicate # of checks performed)	
ILL HEALTH CARE	9,255
CITY OF CHICAGO	1,804
SEC. OF STATE	202
AMERICAN HEALTH CARE	400
MISC. FEES	690
related party-ams	394
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,838

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	215
Seminar Expense	300
related party-ams	16,238
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,753

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	hvac/pipes/pumps/repairs	1/88	$ 3,500	5	$	$	$	$	$	$	$	$	$
2	hvac/pipes/pumps/repairs	2/88	2,444	5									
3	hvac/pipes/pumps/repairs	3/88	2,385	5									
4	hvac/pipes/pumps/repairs	7/88	1,766	5									
5	hvac/pipes/pumps/repairs	10/88	3,200	5									
6	hvac/pipes/pumps/repairs	12/88	2,510	5									
7	boiler/hvac repair	6/89	5,114	5									
8	fan/pump/boiler repairs	10/90	4,240	5									
9	fan/pump/boiler repairs	11/90	3,482	5									
10	fan/pump/boiler repairs	12/90	2,233	5									
11	see page 22a	1991-1995	220,093	5-20	35,018	32,213	2,100	1,540	1,540	1,540	1,540	1,540	1,540
12	see page 22b	1996	41,372	3-20	9,648	5,956	2,976	1,566	696	696	696	696	555
13	see page 22c	1997	16,366	3	5,455	5,455	2,471	0					
14	see page 22c	1998	103,843	3	24,921	34,614	34,614	9,693	0				
15	see page 22d	1999	18,157	3		3,032	6,052	6,052	3,021	0			
16	painting>$1,500 ytd 1999	7/99	12,619	3		2,103	4,206	4,206	2,103	0			
17	see page 22d	2000	15,388	3			2,166	4,997	5,129	2,964	133	0	
18													
19													
20	TOTALS		$ 458,712		$ 75,042	$ 83,373	$ 54,585	$ 28,054	$ 12,489	$ 5,200	$ 2,369	$ 2,236	$ 2,095

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC $9,255**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,397** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **164,250**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **24,417** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BDO SEIDMAN** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **NOT YET COMPLETED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number ALDEN NURSING CENTER - LAKELAND # 0017319 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month/Yr Improvement	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
				FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
Ventalation	3/91	713	5									
HVAC	3/91	1,739	5									
Painting	4/91	2,240	3									
HVAC	9/91	2,297	5									
Boiler	9/91	770	5									
Boiler	1/92	1,393	5									
HVAC	7/92	1,163	5	0								
Boiler	4/93	2377	3									
Boiler	5/93	2,164	3									
Water Pump	5/93	2,680	3									
Boiler	8/93	1,655	3									
HVAC	9/93	3,015	3									
HVAC	10/93	1,453	3									
HVAC	8/94	10,370	5	2,074	1,210	0						
Painting	12/94	140,050	5	28,010	26,843	0						
A/C motor repair	1/95	2,612	5	522	524	0						
Painting	3/95	7,320	5	1,464	1,464	244	0					
Painting	4/95	9,312	3	776								
Pumps	6/95	11,976	15	798	798	798	798	798	798	798	798	798
A/C repair- controls	7/95	1,317	15	88	88	88	88	88	88	88	88	88
A/C motor repair	7/95	2,720	5	544	544	272	0					
Boiler	7/95	2,054	20	103	103	103	103	103	103	103	103	103
Roof exhauster	7/95	441	5	88	88	44	0					
Insullation	7/95	496	15	33	33	33	33	33	33	33	33	33
Compressor	8/95	3,508	15	234	234	234	234	234	234	234	234	234
Water leak	8/95	4,258	15	284	284	284	284	284	284	284	284	284
Total to page 22, line 11		220,093		35,018	32,213	2,100	1,540	1,540	1,540	1,540	1,540	1,540

Facility Name & ID Number ALDEN NURSING CENTER - LAKELAND # 0017319 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month/Yr Improvement	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
				FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006.
Painting	1/96	1,430	3	476	0							
Painting	2/96	1,430	3	437	119	0						
Painting	3/96	2,585	3	862	143	0						
Coils	3/96	2,200	5	440	440	440	73					
Pipes	3/96	4,900	15	327	327	327	327	327	327	327	327	327
Painting	4/96	1,886	3	629	156	0						
Refrigerant	4/96	1,912	10	191	191	191	191	191	191	191	191	50
Condenser cleaning	4/96	1,941	5	388	388	388	98	0				
Painting	5/96	1,610	3	537	178	0						
Condenser leak	5/96	1,824	5	365	365	365	121	0				
Bearings	5/96	3,284	5	657	657	657	218					
Feeder pump and motor	6/96	1,636	15	109	109	109	109	109	109	109	109	109
Boiler	6/96	1,389	20	69	69	69	69	69	69	69	69	69
RemoverRTV and clean	6/96	291	3	97	40	0						
Painting	6/96	2,254	3	751	314	0						
Painting	7/96	1,610	3	537	268	0						
Painting	8/96	1,610	3	537	312	0						
Painting	10/96	3,220	3	1,073	806	0						
Painting	11/96	1,104	3	368	307	0						
New water coil	11/96	2,152	5	430	430	430	360	0				
Painting	12/96	1,104	3	368	337	0						
Total to page 22, line 12		41,372		9,648	5,956	2,976	1,566	696	696	696	696	555

Facility Name & ID Number ALDEN NURSING CENTER - LAKELAND # 0017319 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month/Yr Improvement	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
				FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
replace pump & motor	4/97	2,205	3	735	735	184	0	0	0	0	0	0
replacing mixing valves&pump	4/97	1,053	3	351	351	88	0					
replace belts& motor pulley	7/97	1,800	3	600	600	300	0					
replace valve & drier	7/97	2,686	3	895	895	448	0					
replace butterfly valve	11/97	2,883	3	961	961	801	0					
replaced valves	4/97	2,631	3	877	877	219	0					
replace butterfly valve	6/97	1,539	3	513	513	214	0					
replaced fuses, motor&starter	6/97	1,570	3	523	523	218	0					
Total to page 22, line 13		16,366		5,455	5,455	2,471	0	0	0	0	0	0
Boiler	3/98	2,378	3	660	793	793	133	0				
Drawings	3/98	2,000	3	556	667	667	111	0				
Painting	3/98	36,726	3	10,202	12,242	12,242	2,040	0				
Painting	4/98	6,080	3	1,520	2,027	2,027	507	0				
Painting	4/98	41,270	3	10,317	13,757	13,757	3,440	0				
Painting	7/98	3,574	3	596	1,191	1,191	595	0				
Chiller	7/98	3,026	3	504	1,009	1,009	505	0				
Fan coil units	9/98	1,671	3	186	557	557	371	0				
Painting	10/98	3,276	3	273	1,092	1,092	819	0				
Painting	12/98	3,843	3	107	1,281	1,281	1,174	0				
Total to page 22, line 14		103,843		24,921	34,614	34,614	9,693	0	0	0	0	0

Facility Name & ID Number ALDEN NURSING CENTER - LAKELAND # 0017319 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month/Yr Improvement	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
				FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
Chicago Cooling(start/check a/c)	6/99	4,988	3		970	1,663	1,663	693	0			
Chicago Cooling(charge of a/c)	6/99	2,892	3		562	964	964	402	0			
CSI(cleaned and repair a/c unit)	7/99	2,359	3		393	786	786	393	0			
CSI(cut up dumpsters)	7/99	3,275	3		546	1,092	1,092	546	0			
CSI	8/99	3,122	3		434	1,041	1,041	607	0			
Village Plumbing	10/99	1,523	3		127	508	508	381	0			
Total to page 22, line 15		18,157		0	3,032	6,052	6,052	3,021	0	0	0	0
painting>$1,500 ytd 2000	7/00	7,132	3	0	0	1,189	2,377	2,377	1,189	0		
capps plumbing/sewer-repair plumb	7/00	1,824	3	0	0	304	608	608	304	0		
gt mechanical-replace hvac pump motor	8/00	2,534	3	0	0	351	845	845	493	0		
gt mechanical-repair hvac condens/pump	8/00	2,314	3	0	0	322	771	771	450	0		
capps plumbing/rodding/testing)	4/01	1,585	3				396	528	528	133	0	
Total to page 22, line 17		15,388		0	0	2,166	4,997	5,129	2,964	133	0	0